STATE OF WYOMING-OFFICIAL RECORD OF IMMUNIZATION

Day Care/Pre-School/Head Start/Public and Private Schools K-12

This record is part of the child's or student's permanent record (cumulative folder) and shall transfer with that record. Health Department personnel shall have access to this record as deemed necessary.

PART 1-TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Child/Student: _____ DOB _____
Last First MI Month/Day/Year

Parent/Guardian: _____ Phone: _____

Address: _____ City: _____ Zip: _____

PART 2-TO BE COMPLETED BY PHYSICIAN OR HEALTH AUTHORITY

VACCINE	MONTH, DAY, YEAR EACH DOSE WAS GIVEN				
	1	2	3	4	5
DTAP,DTP,DT (Circle one)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td (Adolescents, Adult)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
POLIO	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
IPV/OPV (Circle below Date)	IPV OPV	IPV OPV	IPV OPV	IPV OPV	IPV OPV
MMR	___/___/___	___/___/___			
SINGLE ANTIGEN(circle as appr.)					
MEASLES	___/___/___	___/___/___			
MUMPS	___/___/___	___/___/___			
RUBELLA	___/___/___	___/___/___			
HAEMOPHILUS INFLUENZAE(HIB) (Licensed Day Care Only)	___/___/___	___/___/___	___/___/___	___/___/___	
HEPATITIS A	___/___/___	___/___/___			
HEPATITIS B	___/___/___	___/___/___	___/___/___		
HEPATITIS B (2 DOSE) (for adolescents 11-15 years only)	___/___/___	___/___/___			
TB test	___/___/___	___/___/___			
VARICELLA	___/___/___	___/___/___			
PNEUMOCOCCAL	___/___/___	___/___/___	___/___/___	___/___/___	
OTHER	___/___/___	___/___/___	___/___/___	___/___/___	

_____ _____
Licensed Physician/Public Health Authority Date

_____ _____
Street Address Official Telephone Number

_____ _____ _____
City State Zip Code

*Health Authority means any State or Local Health Department qualified health personnel or school name.

Provided by Wyoming Vaccines for Children Phone:(307)777-7952 revised by srn 6/03